STATE OF UTAH
DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

APPLICATION FOR LICENSURE

PHYSICIAN ASSISTANT
NOTIFICATION OF CHANGE

APPLICATION INSTRUCTIONS AND INFORMATION

General Statement: The Utah Division of Occupational and Professional Licensing (DOPL) desires to provide courteous and timely service to all applicants for licensure. To facilitate the application process, **submit a complete application form including all applicable supporting documents.** Failure to submit a complete application and supply all necessary information will delay processing and may result in denial of licensure. **Please read all instructions carefully.**

Address of Record: The address you provide on this application will be your address of record. All correspondence from DOPL will be sent to that address. You are responsible to directly notify DOPL of any change to your address of record. Do not rely on a forwarding order.

Social Security Number: Your social security number is classified as a private record under the Utah Government Records Access and Management Act. It is used by DOPL as an individual identifier. It is also used for child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements 42 U.S.C. 666(a)(13). If an SSN is not provided, the application is incomplete and may be denied.

ADDITIONAL IMPORTANT INFORMATION:

1. **Notification of Change:** This form must be submitted to DOPL and approval must be granted **prior** to your adding or changing supervising physicians. The supervising physician shall provide supervision to the physician assistant to adequately serve the health needs of the practice population and ensure the patients' health, safety, and welfare will not be adversely compromised.

2. **Delegation of Services Agreement:** A current "Delegation of Services Agreement" (*attached to this application*) is to be maintained at each of your Utah practice sites and must be available to DOPL upon request.

   <u>Do not</u> submit the Delegation of Services Agreement(s) with this application.

   The agreements contain written criteria jointly developed by you and your supervising physician and substitute supervising physicians that permit you, working under the direction or review of the supervising physicians, to assist in the management of illnesses and injuries common to the physician's scope of practice.

3. **Laws and Rules:** You are responsible to understand all laws and rules pertaining to your

practice. The following applicable laws and rules are available on the Internet at www.dopl.utah.gov:

- Division of Occupational & Professional Licensing Act
- General Rules of the Division of Occupational and Professional Licensing
- Utah Physician Assistant Practice Act
- Utah Physician Assistant Practice Act Rules
- Utah Controlled Substances Act
- Controlled Substance Act Rules of the Division of Occupational and Professional Licensing
- Health Care Providers Immunity from Liability Act

4. **Current Documents:** Applications, statutes, rules, and forms are occasionally changed. Go to www.dopl.utah.gov to ensure you have the most recent version of these documents.

5. **Updating Address Information:** It is your responsibility to maintain a current address with DOPL. If your address is incorrect, you will not receive renewal notices or other correspondence. Address changes can be made online at www.dopl.utah.gov.

6. **Name Change:** If you have been licensed by DOPL under any other name, please submit documentation of your name change (*i.e. copy of a marriage license or divorce decree*).

7. **Mail Complete Application to:**

By U.S. Mail
Division of Occupational & Professional Licensing
P.O. Box 146741
Salt Lake City, Utah 84114-6741

By Delivery or Express Mail
Division of Occupational & Professional Licensing
160 East 300 South, 1st Floor Lobby
Salt Lake City, Utah 84111

8. **Telephone Numbers:** (801) 530-6628
(866) 275-3675 – Toll-free in Utah

9. **Fax Number:** (801) 530-6511

APPLICATION FOR LICENSURE

GENERAL INFORMATION

Application For: **PHYSICIAN ASSISTANT NOTIFICATION OF CHANGE**

Social Security Number: _____

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Gender: ❑ Male ❑ Female Date of Birth: ___/___/____

Have You Ever Held A Utah License Before? ❑ Yes ❑ No

If Yes, Name of Profession: _____

If Yes, License Number: _____

MAILING ADDRESS:

Street: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____

Date License/Certificate Approved: ___/___/____

Approved By: _____

Date License/Certificate Denied: ___/___/____

Denied By: _____

Reason for Denial/Other Comments: _____

PHYSICIAN(S) TO BE REMOVED AS SUPERVISOR(S):

Complete the following form. Use additional sheets if necessary.
The physician(s) listed on this page **will be removed** as supervisor(s).

Primary Supervisor(s):

Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Substitute Supervisor(s):

Substitute Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Substitute Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Substitute Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Substitute Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Substitute Supervising Physician's Name: _____

License Number: _____ Specialty: _____

LIST ALL SUPERVISING PHYSICIAN(S) TO BE APPROVED:

Complete the following for each PRACTICE SITE. Use additional sheets if necessary.
The physician(s) listed on this page will **remain** or **be added** as supervisor(s).

Primary Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Number of physician assistants being supervised (*including this applicant*): _____

Name of Practice Site(s): _____

Address of Practice Site(s): _____

Phone Number of Practice Site(s): _____

Type of Practice: _____

Percent of Direct Supervision: _____

Number of hours working per week: _____

Substitute Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Substitute Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Primary Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Number of physician assistants being supervised (*including this applicant*): _____

Name of Practice Site(s): _____

Address of Practice Site(s): _____

Phone Number of Practice Site(s): _____

Type of Practice: _____

Percent of Direct Supervision: _____

Number of hours working per week: _____

Substitute Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Substitute Supervising Physician's Name: _____

License Number: _____ Specialty: _____

SUMMARY:

Please list all of your supervisor(s) to be approved. Use additional sheets if necessary.

Name: _____ ❑ Primary ❑ Substitute

Name: _____ ❑ Primary ❑ Substitute

Name: _____ ❑ Primary ❑ Substitute

Name: _____ ❑ Primary ❑ Substitute

Name: _____ ❑ Primary ❑ Substitute

Name: _____ ❑ Primary ❑ Substitute

Name: _____ ❑ Primary ❑ Substitute

Name: _____ ❑ Primary ❑ Substitute

Name: _____ ❑ Primary ❑ Substitute

Name: _____ ❑ Primary ❑ Substitute

Name: _____ ❑ Primary ❑ Substitute

AFFIDAVIT:

I declare under penalty of perjury as follows:

I will be practicing as a physician assistant in Utah. I have completed a "Delegation of Services Agreement" with my supervising physician and have reviewed the agreement with each of my substitute supervising physicians.

A copy of the agreement is on file at each of my Utah practice sites and is available to DOPL upon request.

The agreement defines the working relationship and delegation of duties between me and my supervising physician and includes all of the following: the prescribing of controlled substances; the degree and means of supervision; the frequency and mechanism of chart review; procedures addressing situations outside my scope of practice; and procedures for providing backup for me in emergency situations. The written criteria were jointly developed by me and my supervising physician and by me and any substitute supervising physicians. The agreement permits me to work under the direction or review of my supervising physician(s) to assist in the management of illnesses and injuries common to the physician's scope of practice.

Primary Supervising Physician Signature: _____ Date: ___/___/____

Primary Supervising Physician Signature: _____ Date: ___/___/____

Primary Supervising Physician Signature: _____ Date: ___/___/____

Primary Supervising Physician Signature: _____ Date: ___/___/____

PA Applicant Signature: _____ Date: ___/___/____

<u>IF NOT PRACTICING</u> AS A PHYSICIAN ASSISTANT IN UTAH

I declare under penalty of perjury as follows:

I will not be practicing as a Physician Assistant in Utah at this time.

If at any future time I choose to practice in Utah, I agree to complete and submit to DOPL a "Notification of Change" form. I understand that I must receive approval from DOPL <u>before</u> I begin practice with the proposed supervisor(s). I also agree to complete a "Delegation of Services Agreement" consistent with Utah law before I begin my practice in Utah. Said agreement(s) will be on file at my Utah practice site(s).

Physician Assistant Name: _____

Signature of Applicant: _____ Date: ____/____/____

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PHYSICIAN ASSISTANT
DELEGATION OF SERVICES AGREEMENT

A Delegation of Services Agreement is to be maintained at each practice site and is to be available to DOPL upon request. It consists of written criteria jointly developed by a physician assistant's supervising physician and any substitute supervising physicians and the physician assistant that permits a physician assistant, working under the direction or review of the supervising physicians, to assist in the management of illnesses and injuries common to the physician's scope of practice.

The following information must be legible. Use additional sheets if necessary.

DO NOT SUBMIT YOUR DELEGATION OF SERVICES AGREEMENTS TO DOPL WITH YOUR APPLICATION FOR LICENSURE.

Physician Assistant Name: _____

Supervising Physician Name: _____

Utah License Number: _____

Substitute Supervising Physician(s):

Name: _____ Utah License Number: _____

Name: _____ Utah License Number: _____

Name: _____ Utah License Number: _____

Name: _____ Utah License Number: _____

PRACTICE SITE(S):

1. Name of Facility: _____

   Address: _____

   City: _____ State: _____ Zip: _____

2. Name of Facility: _____

   Address: _____

   City: _____ State: _____ Zip: _____

DEGREE AND MEANS OF SUPERVISION:

The supervising physician shall provide supervision to the physician assistant to adequately serve the health care needs of the practice population and ensure that the patient's health, safety, and welfare will not be adversely compromised. There shall be a method of immediate consultation by electronic means whenever the physician assistant is not under the direct supervision of the supervising physician. A physician assistant holding a temporary license may work only under 100% direct supervision. There shall be a method of immediate consultation by electronic means whenever the physician assistant is not under the direct supervision of the supervising physician.

FREQUENCY AND MECHANISM OF CHART REVIEW:

The degree of onsite supervision shall be outlined in the Delegation of Services Agreement maintained at the site of practice. Physician assistants may authenticate with their signature any form that may be authenticated by a physician signature.

PRESCRIBING OF CONTROLLED SUBSTANCES:

A physician assistant may prescribe or administer an appropriate controlled substance if the physician assistant holds a current Utah controlled substance license covering the appropriate schedules of controlled substances and a current DEA registration covering the appropriate schedules of controlled substances; the prescription or administration of the controlled substance is within the prescriptive practice of the supervising physician and also within the delegated prescribing stated in the delegation of services agreement; and the supervising physician co-signs any medical chart record of a prescription of a Schedule 2 or Schedule 3 controlled substance made by the physician assistant.

In order to prescribe controlled substances, the physician assistant must have obtained his or her own controlled substance license and DEA registration. The physician assistant may not use his or her supervising physicians' controlled substance licenses or DEA registrations.

PROCEDURES ADDRESSING SITUATIONS OUTSIDE THE PHYSICIAN ASSISTANT'S SCOPE OF PRACTICE:

PROCEDURES FOR PROVIDING BACKUP FOR THE PHYSICIAN ASSISTANT IN EMERGENCY SITUATIONS:

_____

_____

_____

_____

_____

_____

_____

ADDITIONAL CONSIDERATIONS RELATING TO OUR PRACTICE:

_____

_____

_____

_____

Signature of Physician Assistant: _____

Date of Signature: ___/___/____

Signature of Supervising Physician: _____

Date of Signature: ___/___/____

Signature of Substitute Supervising Physician: _____

Date of Signature: ___/___/____

NOTE: It is "unprofessional conduct" under the Physician Assistant Practice Act to fail to maintain at the practice site(s) a "Delegation of Services Agreement" that accurately reflects current practices; or to fail to make the "Delegation of Services Agreement" available to DOPL for review upon request.